Date: [Date]

To: [Employer Name/Company Name]
From: [Physician Name, MD/DO]
Re: Return to Work Evaluation for [Employee Name]

To Whom It May Concern,

This letter serves to certify that [Employee Name] has been under my care for a pulmonary condition. The patient is cleared to return to work on [Start Date] with the following physical restrictions and accommodations to ensure respiratory safety and recovery:

Physical Activity Restrictions:

- No heavy lifting or strenuous exertion exceeding [Number] pounds.
- Avoid climbing stairs or ladders frequently.
- Allow for frequent rest breaks to manage shortness of breath.
- Sedentary or light duty only until [End Date/Re-evaluation Date].

Environmental Restrictions:

- Avoid exposure to dust, fumes, smoke, or strong chemical odors.
- Work in a temperature-controlled environment; avoid extreme heat or cold.
- Ensure adequate ventilation in the primary workspace.

Medical Requirements:

- The employee must have access to their rescue inhaler or prescribed pulmonary medications at all times.
- [Optional] The employee is permitted to use supplemental oxygen if required.

These restrictions shall remain in effect until [Date]. I will re-evaluate the patient at that time to determine if the restrictions can be lifted or modified.

If you have any questions regarding these medical limitations, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, Printed]
[Medical Practice/Clinic Name]